

REGISTERING AS A PHYSICIAN, PODIATRIST, OPTOMETRIST OR OSTEOPATH

Pursuant to MGL Chapter 112, if you want to operate in Somerville as a physician, podiatrist, optometrist or osteopath, you must register at the City Clerk's Office. To register, fill out the following Registration Transmittal form, attach to it a copy of your Certificate of Registration, and file it with the City Clerk's Office (either in person or by mail):

City Clerk's Office
Somerville City Hall
93 Highland Avenue
Somerville, MA 02143
(617) 625-6600 x4100
<http://www.ci.somerville.ma.us>

Fees

- The fee for registering is \$50.00.
- The fee for changing or terminating a registration is \$25.00.
- Certified copies are \$6.00 each.

The City accepts checks or money orders only by mail, and checks, money orders or cash in person. Checks should be made payable to "City of Somerville."

Term

Once filed, a registration need not be re-filed unless your information changes.

Filing in Person

Bring your Certificate of Registration and a check, money order or cash for the appropriate fee to the address above. You can also bring with you the attached Registration Transmittal form, or fill one out here. The City Clerk's Office accepts registrations Monday-Wednesday, 8:30AM-4:30PM, Thursday 8:30AM-7:30PM, and Friday 8:30AM-12:30PM.

Filing by Mail

To file a registration by mail, fill out the following Registration Transmittal form, attach to it a copy of your Certificate of Registration, and mail it with a check or money order for \$50 to the address above.

To change or terminate a registration by mail, fill out the following Registration Transmittal form and mail it with a check or money order for \$25 to the address above.

The City of Somerville

Physician, Podiatrist, Optometrist or Osteopath Registration Transmittal

Application Fee \$50.00

Date _____

FOR CITY CLERK'S OFFICE ONLY

Date Recorded _____

Amount Paid _____

_____ New Registration

_____ Change in Information

_____ Termination

I, the undersigned, herewith attach a copy of MA Registration Number _____
to the City of Somerville. I intend to conduct the practice of:

_____ Physician

_____ Podiatrist

_____ Optometrist

_____ Osteopath

My office or usual place of business in Somerville is:

Street Address _____

City, State, Zip _____

Telephone _____

I hereby certify that the information above is true and accurate.

Signature _____

Print Name _____